

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13253 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13239

Reg. Dist. No. 201

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena			c. LENGTH OF STAY IN 1b Lifetime			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) near Galena, Md.				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Anderson Last Anderson				4. DATE OF DEATH Month Dec. Day 23 Year 19 57			
5. SEX male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1957	
9. AGE (In years last birthday) yrs. 9		IF UNDER 1 YEAR Months 6 Days 6		IF UNDER 24 HRS. Hours 6 Min. 6			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Anderson				14. MOTHER'S MAIDEN NAME Lillian Chatt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address George Anderson, Galena, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable natural but unknown causes 470x DUE TO Child had a cold for several days but Conditions, if any, which gave rise to immediate cause (b) did not appear acutely ill according to the family. (c) about four hours before death fever developed. cause lost. Death occurred 6:25 P.M. INTERVAL BETWEEN ONSET AND DEATH several days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE <i>Robert W. Farr</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Robert W. Farr, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemty		22d. LOCATION (City, town, or county) (State) Still Pond Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Victor N. Kennedy</i>				ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR DATE 12/24/57	
						24b. REGISTRAR'S SIGNATURE <i>E. Kennedy Jones</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or reinterment.

DEC 30 1957

RECEIVED

James H. Connelley

13254

CERTIFICATE OF DEATH

13240

Reg. Dist. No.

200

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GALENA</u>		c. LENGTH OF STAY IN 1b <u>GALENA X2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>ELIZA</u> Last <u>BUTLER</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 16, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN SEWELL</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE HENRY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>WILSON JOHNSON</u>		Address <u>1302 FRENCH ST. Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u> <u>Same</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>	
20c. TIME OF INJURY Hour o. m. <u>—</u> p. m. <u>—</u> 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 17/57</u> 19 <u>57</u> , to <u>deceased</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 17/57</u> , 19 <u>57</u> , and that death occurred at <u>5:45</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. H. Hamilton</u>		M.D. <u>Millington Maryland</u>	
PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u>		<u>Millington Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>STILL FORD CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>STILL FORD, KENT Co. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		24a. REC'D BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>Ely M. Phelps</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13242

CERTIFICATE OF DEATH

13242

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY IN TB <u>several years</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>238 College Ave.</u>				d. STREET ADDRESS <u>238 College Ave</u>					
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>Cottman</u> Last				4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>1957</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>? ? 1885</u>			
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Samuel Nickerson</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Edna Walley</u> Address <u>238 College Ave. Chestertown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>794x</u> IMMEDIATE CAUSE (a) <u>Senility</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u> a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that I attended the deceased from <u>Dec 14</u> , 19 <u>57</u> , to <u>Dec 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 16</u> , 19 <u>57</u> , and that death occurred at <u>9 9</u> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>E. Kester</u>				ADDRESS (Street, city or town, state) <u>Rock Hall, Md.</u> DATE SIGNED <u>12/18/57</u>					
PHYSICIAN'S NAME (Type) <u>Eugene Kester</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Still Pond Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Still Pond, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walley</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 23 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Clara Barnes</u>					

DEC 23 1957

RECEIVED

13256

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Kent</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Kent</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Still Pond Rural</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>OLLIE</i> Middle <i>HARVEY</i> Last <i>DIXON, SR.</i>		4. DATE OF DEATH Month <i>December</i> Day <i>3</i> Year <i>1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 31, 1897</i>
9. AGE (In years last birthday) <i>60 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARM - CARPENTER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FARM.</i>	
11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William M. Dixon</i>		14. MOTHER'S MAIDEN NAME <i>GRACE CAMP</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>222-12-9380</i>	
17. INFORMANT <i>Family & records carried by deceased</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Internal chest injuries</i> DUE TO (b) <i>Probable coronary thrombosis or</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>cardiac arrest immediately preceding accident.</i> DUE TO <i>accident.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>none</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of form 18.) <i>Ran from car & struck tree; steering wheel produced crushing injury to anterior chest.</i>	
20c. TIME OF INJURY Month, Day, Year <i>12/3 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) (County) (State) <i>near Still Pond Kent md</i>	
21. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> <i>Probably</i> <i>a local attorney was responsible for accident occurring.</i>			
ACTUAL SIGNATURE <i>Robert W. Farr</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>ROBERT W. FARR</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12/6/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>GALENA CEM.</i>		22d. LOCATION (City, town, or county) (State) <i>GALENA MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Hollows, Millington, Md.</i>		24a. REC'D BY REGISTRAR <i>DEC 6 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>E. Howard Jones</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH NO. COUNTY CITY STREET HOUSE NO. APARTMENT NO. ROOM NO. BUILDING NO. DISTRICT NO. WARD NO. PARISH NO. CONGREGATION NO. CHURCH NO. SYNAGOGUE NO. MOSQUE NO. TEMPLE NO. CHAPEL NO. CATHEDRAL NO. MONASTERY NO. CONVENT NO. PRIORY NO. ABBEY NO. HERMITAGE NO. RETIREMENT HOME NO. NURSING HOME NO. HOSPITAL NO. PRISON NO. JAIL NO. BOAT NO. AIRCRAFT NO. OTHER NO. PLACE OF DEATH DATE OF DEATH TIME OF DEATH CAUSE OF DEATH MANNER OF DEATH MEDICAL EXAMINER'S SIGNATURE MEDICAL EXAMINER'S TITLE MEDICAL EXAMINER'S ADDRESS MEDICAL EXAMINER'S CITY MEDICAL EXAMINER'S STATE MEDICAL EXAMINER'S ZIP CODE MEDICAL EXAMINER'S PHONE NO. MEDICAL EXAMINER'S FAX NO. MEDICAL EXAMINER'S E-MAIL ADDRESS MEDICAL EXAMINER'S WEBSITE ADDRESS MEDICAL EXAMINER'S SOCIAL MEDIA ADDRESS MEDICAL EXAMINER'S OTHER CONTACT INFORMATION MEDICAL EXAMINER'S SIGNATURE MEDICAL EXAMINER'S TITLE MEDICAL EXAMINER'S ADDRESS MEDICAL EXAMINER'S CITY MEDICAL EXAMINER'S STATE MEDICAL EXAMINER'S ZIP CODE MEDICAL EXAMINER'S PHONE NO. MEDICAL EXAMINER'S FAX NO. MEDICAL EXAMINER'S E-MAIL ADDRESS MEDICAL EXAMINER'S WEBSITE ADDRESS MEDICAL EXAMINER'S SOCIAL MEDIA ADDRESS MEDICAL EXAMINER'S OTHER CONTACT INFORMATION	
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DEC 6 1957
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G223 12-26-57 et

13243

CERTIFICATE OF DEATH

13244

Reg. Dist. No.

203

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert St.</u>				d. STREET ADDRESS <u>Calvert St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Leon</u> Middle <u>Fletcher</u> Last <u>Fletcher</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 11, 1912</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>various</u>		11. BIRTHPLACE (State or foreign country) <u>Chester, Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Leon Fletcher</u>				14. MOTHER'S MAIDEN NAME <u>Don't Know</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u>171-10-9531</u>		17. INFORMANT <u>Betty Fletcher</u> <u>434 Calvert St. (wife)</u> <u>Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>592x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Glomerulonephritis</u> DUE TO (c) <u>Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>6 months</u> <u>6 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>1957</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>December</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>December 15</u> , 19 <u>57</u> , and that death occurred at <u>9:30 p.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>12-16-57</u>							
ACTUAL SIGNATURE <u>A.C. Dick</u>				PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Janes Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walley</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 20 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>			

BUREAU V. S.

DEC 20 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13245

13244

Item 7 Film 224 1-3-50 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne Co. Hosp. (DOA)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Earl Last Green		4. DATE OF DEATH Month Dec. Day 25 Year 1957	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1925
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY various	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Earl Green		14. MOTHER'S MAIDEN NAME Lillian Carter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. 212-16-1386	
17. INFORMANT Myrtle Saunders		Address 238 College Ave Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from stab wound 982x DUE TO involuntary contraction and asphyxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ulcer / appendage DUE TO (c) Stomach		INTERVAL BETWEEN ONSET AND DEATH Stomach	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 5:00 a.m. 12/25 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Home		20f. (City or town) (County) (State) Chestertown Kent Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		DATE SIGNED 12/25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28 /57	
22c. NAME OF CEMETERY OR CREMATORY Rich Neck Hall Cem.		22d. LOCATION (City, town, or county) (State) Mr. Church Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS J. Willis Wells	
24a. REC'D BY REGISTRAR DATE 30 1957		24b. REGISTRAR'S SIGNATURE Clara Barnes	

NAVY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
RESIDENCE		OCCUPATION		EDUCATION		MILITARY SERVICE		MILITARY SERVICE		MILITARY SERVICE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY	
FAMILY HISTORY		SOCIAL HISTORY		HISTORY OF PRESENT ILLNESS		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		POSTMORTEM EXAMINATION	
SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	

BUREAU V. F.

DEC 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13245

CERTIFICATE OF DEATH

13246

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland Queen Annes	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 21 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Kent and Queen Anne's		d. STREET ADDRESS Roberts Station	
3. NAME OF DECEASED (Type or print) First Middle Last Walter Haskins		4. DATE OF DEATH Month Day Year December 14, 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 9, 1871
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Farm		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Haskins		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Hosp. records Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complications of old age 141X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cancer of tongue			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-13, 19 57, to 12-14, 19 57, that I last saw the deceased alive on 12-13, 19 57, and that death occurred at 10:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A.C. Dick		DATE SIGNED 12-14-57	
PHYSICIAN'S NAME (Type) A.C. Dick, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/57	
22c. NAME OF CEMETERY OR CREMATORY Barclay		22d. LOCATION (City, town, or county) (State) Barclay, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.E. Boulain		24a. REC'D BY REGISTRAR Dec. 17-1957	
ADDRESS Greensboro, Md.		24b. REGISTRAR'S SIGNATURE Charles S. Barnes	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

DATE

PLACE OF DEATH

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BUREAU V. S.

DEC 19 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13246

CERTIFICATE OF DEATH

13247

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN			c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ MILLINGTON		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & QUEEN ANNE'S Hosp				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRED W. JARRELL				4. DATE OF DEATH Month Day Year DEC 23 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 14, 1880		9. AGE (In years lost birthday) yrs. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSHUA JARRELL				14. MOTHER'S MAIDEN NAME EMMA CORNELIUS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT HOSPITAL CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO-SCLEROTIC HEART DISEASE DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) POST-OPERATIVE STATE CHOLECYSTECTOMY							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DEC 20, 1957 , to DEC 23, 1957 , that I last saw the deceased alive on DEC 23, 1957 , and that death occurred at 10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) CHESTERTOWN Md DATE SIGNED 12-23-57							
ACTUAL SIGNATURE G. J. Keefe		M.D. —					
PHYSICIAN'S NAME (Type) A. T. KEEFE, JR. MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 26/57		22c. NAME OF CEMETERY OR CREMATORY Still Pond Cemetery		22d. LOCATION (City, town, or county) (State) Still Pond Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams				ADDRESS Chestertown, Md		24a. REC'D BY REGISTRAR Dec. 28-1957	
				24b. REGISTRAR'S SIGNATURE Clara S. Barnes			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13247

CERTIFICATE OF DEATH

13248

Reg. Dist. No.

202

1. PLACE OF DEATH o. COUNTY Kent MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital 2 days			d. STREET ADDRESS 107 Prospect St.		
3. NAME OF DECEASED (Type or print) First Sarah Middle Johnson Last Johnson			4. DATE OF DEATH Month Dec. Day 15 , Year 1957		
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1886		9. AGE (In years last birthday) yrs. 70
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY domestic		11. BIRTHPLACE (State or foreign country) Kent Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Henry Hynson		
14. MOTHER'S MAIDEN NAME Lottie Maddox			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. 218-30-1532			17. INFORMANT Clara Matthews Address 107 Prospect St. Chestertown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock - & overwhelming infection 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spinal Meningitis DUE TO (c) 2 hours 2 DAYS					INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia - Positive Serology					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 12/13 , 19 57 , to 12/15 , 19 57 , that I last saw the deceased alive on 12/16 , 19 57 , and that death occurred at M , from the causes and on the date stated above.					
ACTUAL SIGNATURE Thomas J. Solon		M.D. Chestertown		DATE SIGNED 12/15/57	
PHYSICIAN'S NAME (Type) Thomas J. Solon		ADDRESS Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 1957		22c. NAME OF CEMETERY OR CREMATORY Janes Cemetery	
22d. LOCATION (City, town, or county) Chestertown, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DEC 20 1957	
24b. REGISTRAR'S SIGNATURE Clara Matthews					

CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. CAUSE OF DEATH [Illegible]		9. MANNER OF DEATH [Illegible]	
10. DATE OF DEATH [Illegible]		11. PLACE OF DEATH [Illegible]		12. SIGNATURE OF PHYSICIAN [Illegible]	
13. SIGNATURE OF REGISTRAR [Illegible]		14. SIGNATURE OF WITNESS [Illegible]		15. SIGNATURE OF DECEASED [Illegible]	
16. SIGNATURE OF DECEASED [Illegible]		17. SIGNATURE OF DECEASED [Illegible]		18. SIGNATURE OF DECEASED [Illegible]	
19. SIGNATURE OF DECEASED [Illegible]		20. SIGNATURE OF DECEASED [Illegible]		21. SIGNATURE OF DECEASED [Illegible]	
22. SIGNATURE OF DECEASED [Illegible]		23. SIGNATURE OF DECEASED [Illegible]		24. SIGNATURE OF DECEASED [Illegible]	
25. SIGNATURE OF DECEASED [Illegible]		26. SIGNATURE OF DECEASED [Illegible]		27. SIGNATURE OF DECEASED [Illegible]	
28. SIGNATURE OF DECEASED [Illegible]		29. SIGNATURE OF DECEASED [Illegible]		30. SIGNATURE OF DECEASED [Illegible]	
31. SIGNATURE OF DECEASED [Illegible]		32. SIGNATURE OF DECEASED [Illegible]		33. SIGNATURE OF DECEASED [Illegible]	
34. SIGNATURE OF DECEASED [Illegible]		35. SIGNATURE OF DECEASED [Illegible]		36. SIGNATURE OF DECEASED [Illegible]	
37. SIGNATURE OF DECEASED [Illegible]		38. SIGNATURE OF DECEASED [Illegible]		39. SIGNATURE OF DECEASED [Illegible]	
40. SIGNATURE OF DECEASED [Illegible]		41. SIGNATURE OF DECEASED [Illegible]		42. SIGNATURE OF DECEASED [Illegible]	
43. SIGNATURE OF DECEASED [Illegible]		44. SIGNATURE OF DECEASED [Illegible]		45. SIGNATURE OF DECEASED [Illegible]	
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52. SIGNATURE OF DECEASED [Illegible]		53. SIGNATURE OF DECEASED [Illegible]		54. SIGNATURE OF DECEASED [Illegible]	
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64. SIGNATURE OF DECEASED [Illegible]		65. SIGNATURE OF DECEASED [Illegible]		66. SIGNATURE OF DECEASED [Illegible]	
67. SIGNATURE OF DECEASED [Illegible]		68. SIGNATURE OF DECEASED [Illegible]		69. SIGNATURE OF DECEASED [Illegible]	
70. SIGNATURE OF DECEASED [Illegible]		71. SIGNATURE OF DECEASED [Illegible]		72. SIGNATURE OF DECEASED [Illegible]	
73. SIGNATURE OF DECEASED [Illegible]		74. SIGNATURE OF DECEASED [Illegible]		75. SIGNATURE OF DECEASED [Illegible]	
76. SIGNATURE OF DECEASED [Illegible]		77. SIGNATURE OF DECEASED [Illegible]		78. SIGNATURE OF DECEASED [Illegible]	
79. SIGNATURE OF DECEASED [Illegible]		80. SIGNATURE OF DECEASED [Illegible]		81. SIGNATURE OF DECEASED [Illegible]	
82. SIGNATURE OF DECEASED [Illegible]		83. SIGNATURE OF DECEASED [Illegible]		84. SIGNATURE OF DECEASED [Illegible]	
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88. SIGNATURE OF DECEASED [Illegible]		89. SIGNATURE OF DECEASED [Illegible]		90. SIGNATURE OF DECEASED [Illegible]	
91. SIGNATURE OF DECEASED [Illegible]		92. SIGNATURE OF DECEASED [Illegible]		93. SIGNATURE OF DECEASED [Illegible]	
94. SIGNATURE OF DECEASED [Illegible]		95. SIGNATURE OF DECEASED [Illegible]		96. SIGNATURE OF DECEASED [Illegible]	
97. SIGNATURE OF DECEASED [Illegible]		98. SIGNATURE OF DECEASED [Illegible]		99. SIGNATURE OF DECEASED [Illegible]	
100. SIGNATURE OF DECEASED [Illegible]		101. SIGNATURE OF DECEASED [Illegible]		102. SIGNATURE OF DECEASED [Illegible]	

RECEIVED
DEC 20 1957
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13257 CERTIFICATE OF DEATH

13242
Reg. Dist. No. 200

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 MILLINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>J.</u> Middle <u>CRAIG</u> Last <u>JOHNSTON</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 26, 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>DEL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JAMES JOHNSTON</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE JEFFERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-26-1998</u>	
17. INFORMANT <u>E. EVERETT JOHNSTON</u>		Address <u>MILLINGTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Virus pneumonia</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>8 weeks.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>492X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 27, 1957</u> , to <u>Dec. 7, 1957</u> , that I last saw the deceased alive on <u>Dec. 6, 1957</u> , and that death occurred at <u>7 A. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edw. J. Kowalski</u>		DATE SIGNED <u>12.8.57</u>	
PHYSICIAN'S NAME (Type) <u>DR. GEZA KOPALEWSKI</u>		M.D. <u>MILLINGTON, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/11/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>STILL POND CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>STILL POND, KENT CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		24. REC'D BY REGISTRAR <u>Edward Fellows</u>	
ADDRESS <u>Millington, Md.</u>		DATE <u>11-11-1957</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

13258 CERTIFICATE OF DEATH

13250

Reg. Dist. No. 201

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b adult life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home Rural		d. STREET ADDRESS RFD Morgnac	
3. NAME OF DECEASED (Type or print) Kitty First L. Middle Knox Last		4. DATE OF DEATH Dec. 16, 1957 Month Dec. Day 16 Year 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 9, 1897
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Queen Anne Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Chambers		14. MOTHER'S MAIDEN NAME Mary E. Jarmar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Enoch Knox Address Chestertown, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident DUE TO Hypertension, arteriosclerotic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) year DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/16, 1957 , to 12/16, 1957 , that I last saw the deceased alive on 12/16, 1957 , and that death occurred at 11 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Solon		ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 12/17/57	
PHYSICIAN'S NAME (Type) Thomas J. Solon		Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/19/57	22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DEC 2 1957 24b. REGISTRAR'S SIGNATURE E. K. Jones	

RECEIVED

DEC 28 1967

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13248

CERTIFICATE OF DEATH

13251

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION High St.				d. STREET ADDRESS 1 High St.			
3. NAME OF DECEASED (Type or print) First Edward Middle Cordray Last Loud				4. DATE OF DEATH Dec. 14, 1957 Month Dec. Day 14 Year 1957			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 24, 1882	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer of Wood for pulp				10b. KIND OF BUSINESS OR INDUSTRY Kent Co. Md.			
11. BIRTHPLACE (State or foreign country) Kent Co. Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Cordray Loud				14. MOTHER'S MAIDEN NAME Anne B. Groves			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-I8-4210			
17. INFORMANT Marietta Loud				Address High St. Chestertown, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of bladder DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 3 years 7 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1957 , to December 14, 1957 , that I last saw the deceased alive on 12-13 , 19 57 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 12-15-57							
ACTUAL SIGNATURE A. C. Dick M.D.							
PHYSICIAN'S NAME (Type) A. C. Dick							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/16/57		22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chestertown, Md.		24. REGISTRY BY REGISTRAR DEC 17 1957	
24b. REGISTRAR'S SIGNATURE Clara Harney							

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. MEDICAL HISTORY		11. PREVIOUS ILLNESS		12. OTHER FACTS	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS		16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF OTHER	
19. DATE OF DEATH		20. TIME OF DEATH		21. PLACE OF DEATH		22. PLACE OF BIRTH		23. PLACE OF DEATH		24. PLACE OF BIRTH	
25. DATE OF DEATH		26. TIME OF DEATH		27. PLACE OF DEATH		28. PLACE OF BIRTH		29. PLACE OF DEATH		30. PLACE OF BIRTH	

BUREAU V. B.

DEC 17 1957

RECEIVED

13259

CERTIFICATE OF DEATH

13252

Reg. Dist. No. 200

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GALENA</u>		c. LENGTH OF STAY IN 1b <u>GALENA X2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>LOTTIE</u> First <u>H.</u> Middle <u>NEWNAM</u> Last		4. DATE OF DEATH Month <u>DEC.</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 6, 1882</u> yrs. <u>75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HIRAN POWELL</u>		14. MOTHER'S MAIDEN NAME <u>MARY VIBLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FRANK NEWNAM</u>		Address <u>GALENA MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic Renal Disease</u> DUE TO (c) <u>unknown.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs 11 m</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 26, 1956</u> to <u>29 Dec., 1957</u> that I last saw the deceased alive on <u>Dec 29, 1957</u> , and that death occurred at <u>2:42</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace Ohnuchain</u> M.D.		DATE SIGNED <u>1 Jan 58</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/2/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GALENA CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>GALENA, KENT CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		24a. REC'D BY REGISTRAR <u>1958</u> DATE	
ADDRESS <u>Millington Rd</u>		24b. REGISTRAR'S SIGNATURE <u>By Mullins</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13249

CERTIFICATE OF DEATH

13253

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Chestertown(rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ADA Middle CATHERINE Last PLUMMER		4. DATE OF DEATH Month December Day 26 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1893
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Austin		14. MOTHER'S MAIDEN NAME Mary Isaacs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NO.	
17. INFORMANT Family & Hospital Records, Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Renal Disease with Hypertension & Generalized Arteriosclerosis & Congestive Failure 260x DUE TO Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 years 3 years known		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 9. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 2, 1957 , to December 26, 1957 , that I last saw the deceased alive on December 26, 1957 , and that death occurred at 11:40P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Farr		ADDRESS (Street, city or town, state) Chestertown, Md.	
PHYSICIAN'S NAME (Type) Robert W. Farr		DATE SIGNED December 26, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/30/57	
22c. NAME OF CEMETERY OR CREMATORY Gracelawn Mem. Park		22d. LOCATION (City, town, or county) (State) nr. Wilmington, Dela.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Clara Barney	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF CLERGYMAN		16. SIGNATURE OF BURIAL OFFICIAL		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF OTHER	
19. SIGNATURE OF		20. SIGNATURE OF		21. SIGNATURE OF		22. SIGNATURE OF		23. SIGNATURE OF		24. SIGNATURE OF	
25. SIGNATURE OF		26. SIGNATURE OF		27. SIGNATURE OF		28. SIGNATURE OF		29. SIGNATURE OF		30. SIGNATURE OF	
31. SIGNATURE OF		32. SIGNATURE OF		33. SIGNATURE OF		34. SIGNATURE OF		35. SIGNATURE OF		36. SIGNATURE OF	
37. SIGNATURE OF		38. SIGNATURE OF		39. SIGNATURE OF		40. SIGNATURE OF		41. SIGNATURE OF		42. SIGNATURE OF	
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103. SIGNATURE OF		104. SIGNATURE OF		105. SIGNATURE OF		106. SIGNATURE OF		107. SIGNATURE OF		108. SIGNATURE OF	
109. SIGNATURE OF		110. SIGNATURE OF		111. SIGNATURE OF		112. SIGNATURE OF		113. SIGNATURE OF		114. SIGNATURE OF	
115. SIGNATURE OF		116. SIGNATURE OF		117. SIGNATURE OF		118. SIGNATURE OF		119. SIGNATURE OF		120. SIGNATURE OF	
121. SIGNATURE OF		122. SIGNATURE OF		123. SIGNATURE OF		124. SIGNATURE OF		125. SIGNATURE OF		126. SIGNATURE OF	
127. SIGNATURE OF		128. SIGNATURE OF		129. SIGNATURE OF		130. SIGNATURE OF		131. SIGNATURE OF		132. SIGNATURE OF	
133. SIGNATURE OF		134. SIGNATURE OF		135. SIGNATURE OF		136. SIGNATURE OF		137. SIGNATURE OF		138. SIGNATURE OF	
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145. SIGNATURE OF		146. SIGNATURE OF		147. SIGNATURE OF		148. SIGNATURE OF		149. SIGNATURE OF		150. SIGNATURE OF	
151. SIGNATURE OF		152. SIGNATURE OF		153. SIGNATURE OF		154. SIGNATURE OF		155. SIGNATURE OF		156. SIGNATURE OF	
157. SIGNATURE OF		158. SIGNATURE OF		159. SIGNATURE OF		160. SIGNATURE OF		161. SIGNATURE OF		162. SIGNATURE OF	
163. SIGNATURE OF		164. SIGNATURE OF		165. SIGNATURE OF		166. SIGNATURE OF		167. SIGNATURE OF		168. SIGNATURE OF	
169. SIGNATURE OF		170. SIGNATURE OF		171. SIGNATURE OF		172. SIGNATURE OF		173. SIGNATURE OF		174. SIGNATURE OF	
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BUREAU V. 3

DEC 10 1957

RECEIVED

13250

CERTIFICATE OF DEATH

13254

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Chestertown 17x0 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Water St.				d. STREET ADDRESS Kingstown			
3. NAME OF DECEASED (Type or print) First ANNA C. Middle RHOADES Last				4. DATE OF DEATH Month Dec. Day 6/57 Year 19 5			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15 1889	9. AGE (In years last birthday) 67 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Berlin New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bouffard				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Frederick H. Keer-Chestertown, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arterio Sclerosis and arterial hypertension with (c) probable disturbance to conduction mechanism						INTERVAL BETWEEN ONSET AND DEATH none several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6 , 19 57 , to Dec. 6 , 19 57 , that I last saw the deceased alive on Dec. 6 , 19 57 , and that death occurred at 5:00 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 12/7/57 ACTUAL SIGNATURE Robert W. Farr, M. D. M.D. PHYSICIAN'S NAME (Type) Robert W. Farr, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 9 /57		22c. NAME OF CEMETERY OR CREMATORY Darlington Cemetery		22d. LOCATION (City, town, or county) (State) Darlington Hartford Co.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams				24a. REC'D BY REGISTRAR Dec. 10-1957		24b. REGISTRAR'S SIGNATURE Clara S. Barnes	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN A. SMITH		2. SEX Male		3. AGE 45	
4. DATE OF DEATH Dec 10 1957		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. OCCUPATION Salesman		11. MARITAL STATUS Married		12. EDUCATION High School	
13. PREVIOUS ILLNESS None		14. MEDICAL HISTORY Hypertension		15. TREATMENT None	
16. SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		17. SIGNATURE OF DECEASED None		18. SIGNATURE OF WITNESSES None	

BUREAU V. 1

DEC 12 1957

RECEIVED

13251

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			c. LENGTH OF STAY IN 1b life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 Wash. Ave.				d. STREET ADDRESS 204 Wash. Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARGARET Middle MAY Last SIDES				4. DATE OF DEATH Month Dec. 8 / Day 57 Year 19			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23 1877		9. AGE (In years last birthday) yrs. 80	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Templeville Q.A. Co. Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Wm. G. Fallowfield				14. MOTHER'S MAIDEN NAME Margaret Wallace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Elsie G. Russell, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Insufficiency DUE TO (b) Coronary arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 15 OR 20 minutes Don't know	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Dec. 18, 19 57, to Dec. 81, 19 57, that I last saw the deceased alive on Dec. 18, 19 57, and that death occurred at 9:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12/10/57							
ACTUAL SIGNATURE Robert W. Farr, M. D.,				Chestertown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 11/57		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR Dec. 12-1957	
				24b. REGISTRAR'S SIGNATURE Clara S. Barnes			

CERTIFICATE OF DEATH

<p>NAME OF DECEASED JAMES J. JONES</p>		<p>AGE 35</p>		<p>SEX Male</p>		<p>RACE White</p>	
<p>DATE OF DEATH Dec 15 1957</p>		<p>PLACE OF DEATH Home</p>		<p>CITY Boston</p>		<p>COUNTY Suffolk</p>	
<p>CAUSE OF DEATH Heart Disease</p>		<p>IMMEDIATE CAUSE Myocardial Infarction</p>		<p>UNDERLYING CAUSE Coronary Artery Disease</p>		<p>OTHER CAUSE None</p>	
<p>DATE OF BIRTH Oct 10 1922</p>		<p>PLACE OF BIRTH Boston</p>		<p>CITY Boston</p>		<p>COUNTY Suffolk</p>	
<p>DATE OF DEATH Dec 15 1957</p>		<p>PLACE OF DEATH Home</p>		<p>CITY Boston</p>		<p>COUNTY Suffolk</p>	
<p>CAUSE OF DEATH Heart Disease</p>		<p>IMMEDIATE CAUSE Myocardial Infarction</p>		<p>UNDERLYING CAUSE Coronary Artery Disease</p>		<p>OTHER CAUSE None</p>	
<p>DATE OF BIRTH Oct 10 1922</p>		<p>PLACE OF BIRTH Boston</p>		<p>CITY Boston</p>		<p>COUNTY Suffolk</p>	

BUREAU V. S.

DEC 16 1957

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may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13252 CERTIFICATE OF DEATH

13256

Reg. Dist. No.

20x

1. PLACE OF DEATH o. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes, Chestertown, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golt X/ (rural)	
		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Naby Boy Middle Zook Last Zook		4. DATE OF DEATH Month December Day 15 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 14, 1957
9. AGE (In years last birthday) yrs. 12		IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Aaron King Zook		14. MOTHER'S MAIDEN NAME Mary Beiler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Distress Fetal Atalectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Premature birth (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 12 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/14, 1957 , to 12/15, 1957 , that I last saw the deceased alive on December 15, 1957 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Farr		ADDRESS (Street, city or town, state) Chestertown, Md.	
DATE SIGNED 12/15/57			
PHYSICIAN'S NAME (Type) ROBERT W. FARR,		Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/16/57	22c. NAME OF CEMETERY OR CREMATORY Lake Cock Cem.	22d. LOCATION (City, town, or county) (State) Lancaster Co. Penna.
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DEC 17 1957		24b. REGISTRAR'S SIGNATURE Clara Barnes	

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WISCONSIN STATE DEPARTMENT OF HEALTH—MILWAUKEE, WIS.